

Client Information

Client Name: _____ **Date of Birth:** _____

Gender: M F Other **Marital Status:** Single Married Cohabiting Other

Employment: Full-time Student Part-time Student Employed Unemployed/Other

Address: _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____
 Mobile Work Home

Voice messages Yes No Email messages Yes No Email appt. reminders Yes No

Person Responsible for Payment (skip if same as above)

Name: _____ **Relationship to Client:** Spouse Partner
 Parent Other: _____

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____

Payment Contact: Voice messages Yes No Email messages Yes No

Primary Insurance

Insured's Name: _____ **Date of Birth:** _____ **Gender:** M F

Insured's Relationship to Client: Self Parent Stepparent Guardian Spouse Partner
 Other: _____ **Company/School:** _____

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____

Secondary Insurance Yes No **Plan:** BCBS of AZ Aetna Other: _____

Emergency Contact

Name: _____ **Relationship to Client:** Spouse Partner
 Parent Other: _____

Address: Same as client _____
Street City State Zip

Preferred Phone: _____ **Preferred Email:** _____

Emergency Contact: Voice messages Yes No Email messages Yes No

Primary Care Physician

Name: _____ **Practice:** _____ **Phone:** _____